

Inter-Hospital Coordinating Council



Preparedness Planning Guidelines

January 2018

Approval and Implementation Document

**Inter-Hospital Coordinating Council
Preparedness Planning Guidelines**

This Plan is hereby approved for implementation.

Date Preparedness Planning Guidelines Approved: January 12, 2018

APPROVAL OF PREPAREDNESS PLAN: This Guideline is adopted with review by coalition membership and approval by Coalition Core Members.

**Inter-Hospital Coordinating Council
Preparedness Planning Guidelines
Record of Changes**

Date of Revision	Recommended Change	Revision Number	Initials

**Inter-Hospital Coordinating Council
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Record of Distribution**

To Whom: Person/Title/Agency	Method of Delivery	Date

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1. Introduction

The guideline describes the roles and responsibilities of the Inter-Hospital Coordinating Council (IHCC) in preparing for a public health/healthcare emergency within the region of Washoe County. The coalition can further support preparedness efforts in other regions of the state if needed.

1.1 Propose of Guidelines:

The IHCC Preparedness Planning Guidelines establishes and describes the emergency response framework and will guide the IHCC as it prepares to protect the health, safety, and well-being of Washoe County residents and visitors in areas impacted by a natural or manmade health emergency or disaster.

1.2 Scope

This guideline utilizes the input of its members, partners and the planning tools to identify the assets, resources and gaps of geographical boundaries of the coalition.

1.3 Administrative Role

This guideline is to be reviewed at least annually and approved by the core membership and general census of non-voting members and partners.

2. Coalition Overview

2.1 Introduction/Purpose of Coalition

The IHCC was organized in 1994, for the purpose of collaborating and coordinating the efforts of healthcare facilities and community stakeholders, to mitigate against, prepare for, respond to, and recover from, hazards impacting Northern Nevada's healthcare community and their patients. Activities of the IHCC shall include, but are not limited to:

- i. Collaborating and sharing preparedness information between healthcare organizations and community preparedness partners.
- ii. Coordinating preparedness activities and training among healthcare organizations and community preparedness partners.
- iii. Sharing information, best practices, and lessons learned between healthcare organizations and community preparedness partners.

2.2 Coalition Boundaries

The coalition boundaries are confined to the jurisdictional boundaries of Washoe County.

2.3 Coalition Members

Membership shall extend to any North Western Nevada or North Eastern California healthcare organization (acute care hospital, sub-acute care hospital, behavioral health hospital, skilled nursing facility, ambulatory care center, healthcare associations, etc.) and their agreed upon community preparedness partners (public health, local emergency management, local fire/EMS, local law enforcement, etc.). Membership includes voting and non-voting members.

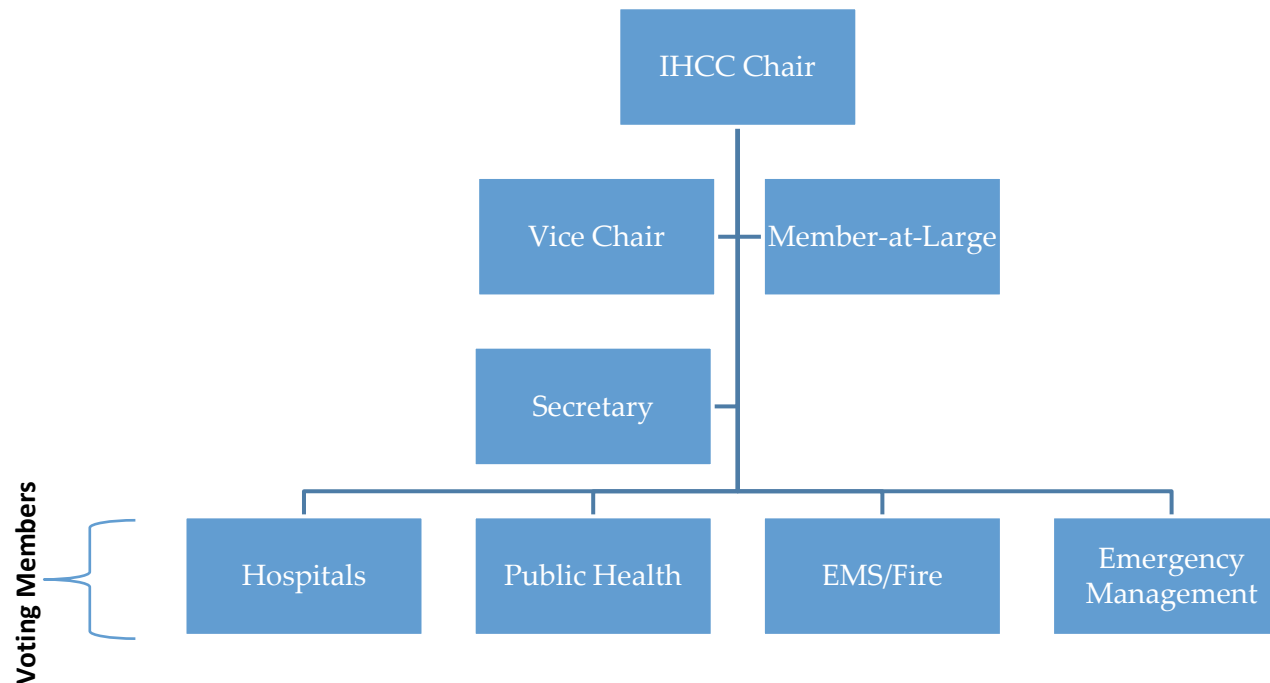
Voting membership is comprised of the Hospitals, Emergency Medical Services, Emergency Management organizations, and Public Health agencies located within Washoe County. These entities are recognized as the core members and are outlined in the attendance record. Additional voting members must be voted in by the IHCC. Each entity only has one vote.

Non-voting membership shall be extended to any entity considered to be a partner in healthcare preparedness, but who does not qualify for voting membership (State and Federal Agencies, casinos, ARES, skilled nursing facility, associations, etc.). If a non-voting member wishes to be a voting member, they must be voted in by the IHCC core membership. IHCC values non-voting membership and respects their involvement and contribution to the coalition.

Please reference IHCC current attendance list for current membership.

2.4 Organizational Structure/ Governance

Below is an outline of the organizational structure of the coalition. Reference the IHCC bylaws for completed organization structure and governance.



Non-voting members include: Behavioral health services and organizations, CERT, MRC, dialysis centers, federal facilities, home health agencies, infrastructure companies, jurisdictional partners, tribes, local chapters of health care progression organizations, local public health safety agencies, medical and device manufacturers and distributors, non-governmental organizations, outpatient health care delivery, urgent care centers, primary care providers, schools and universities, support service providers, child care services, dental clinics, social work services, and faith-based organizations.

2.4.1 Role of Leadership within Member Organizations

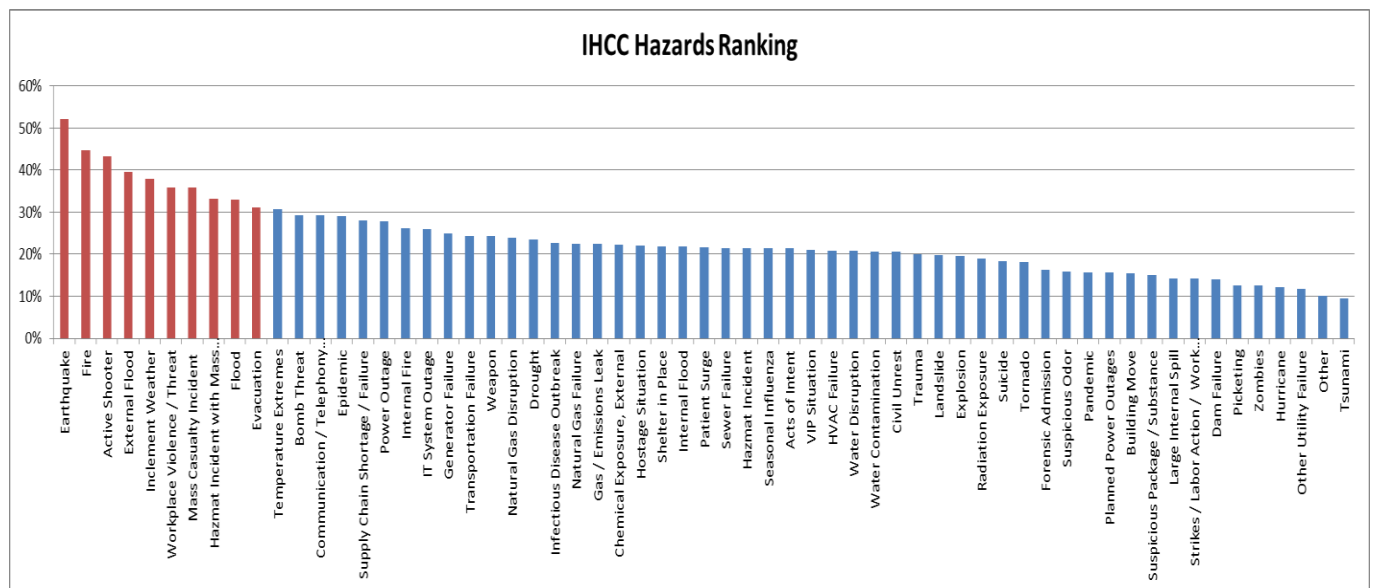
At the beginning of each calendar year, all members sign the IHCC Memorandum of Understanding (MOU). The agreement creates a voluntary agreement on common goals and expectations. See Appendix 5.1 for complete MOU.

2.5 Risk

This section summarizes the results of the coalitions Hazard Vulnerability Assessment (HVA). A standardized template was developed, vetted through the IHCC Preparedness Plan Workgroup and approved by IHCC membership. The HVA template was modified from the Kaiser Permanente HVA Tool 2017. It was decided to use a standardized tool to compile the data.

The top 10 hazards as identified through the coalition's HVA are as follows:

1. Earthquake -52%
2. Fire -45%
3. Active Shooter -43%
4. External Flood -40%
5. Inclement Weather - 38%
6. Workplace Violence Threat - 36%
7. Mass Casualty Incident- 36%
8. Hazmat Incident with Mass Casualties -33%
9. Flood - 33%
10. Evacuation -31%



The HVA data was collected from all six voting members, eight of eleven non-voting members, and two coalition guests. The facilities that participated in the HVA are as follows:

Voting Members: Incline Village Community Hospital, Northern Nevada Adult Mental Health Services, Northern Nevada Medical Center, Renown Regional Medical Center and Renown South Meadows, Saint Mary's Regional Medical Center, and Tahoe Pacific Hospitals.

Non-Voting Members: Community Health Alliance, Donor Network West, Life Care Center of Reno, ManorCare Health Services – Wingfield, Quail Surgery Center, Renown Rehabilitation Hospital, Surgery Center of Reno, and Tahoe Forest Hospital.

Guests: Renown Hospice and Summit Surgery Center

In addition to compiling the data from the members, the Workgroup developed a weighting mechanism (as outlined below).

Healthcare Provider Type	Weighted Score
Acute Care Hospital	1
Long-term Care/Skilled Nursing Facilities	0.5
Home Health/Hospice	0.4
Federally Qualified Health Centers/Clinics	0.3
Ambulatory Surgical Centers	0.2
Other	0.1

See Appendix 5.2 for complete coalition HVA.

The coalition also reviews and approves the Jurisdictional Risk Assessment (JRA) every two years. The JRA was last completed in 2016 and is utilized when measuring the progress of the coalition and gaps.

2.6 Resources and Gaps

This section summarizes the results of the coalition survey. The survey targeted five provider types (hospitals, long-term care, outpatient, public health, EMS/Fire, and coalition leadership).

The purpose of the survey was to assist the coalition to develop a common understanding of its resources and gaps, and assist in prioritizing activities to mitigate gaps. The survey, a resource and gap analysis, was developed from the ASPR TRACIE Healthcare Coalition Resource and Gap Analysis. The survey identified gaps, such as inadequate plans, staffing, equipment and supplies, skills and expertise, services, and any other resource required to respond during an emergency.

The survey was developed in Survey Monkey and was available to coalition members. Depending on provider type, a member was given a series of questions. The results were averaged among member responses and put into the ASPR TRACIE Healthcare Coalition Resource and Gap Analysis tool. Once the results were put into the tool, four meetings were held to review the results from

hospitals, EMS/Fire, long-term care, and outpatient; the top three priority areas were identified during the meetings.

The top preparedness gaps by provider type, as identified through the coalition's resource and gap analysis are as follows:

EMS/FIRE:

1. EMS Active Shooter/Armed Assailant/Active Threat Response
2. EMS Exercise Plan
3. EMS Specialty Mass Casualty Plan

Hospital:

1. Hospital Surgical/Burn MCI Plan
2. Hospital COOP, Recovery/Business Continuity Plan
3. Hospital Pediatric MCI Plan

Long-term Care (LTC):

1. LTC Infectious Disease Plan
2. Evacuation Plan (alternate care site)

3. LTC Exercise Plan

Public Health:

1. Alternate Care Site Plan
2. Public Health Shelter Support Plan (medical services)
3. Public Health Legal/Regulatory Plan

Outpatient:

1. Outpatient Care Emergency Operations Plan
2. Outpatient Care Staff and Resources Sharing Plan/ Care Surge Capacity Plan

A few questions worth noting, not outlined in the ASPR TRACIE Healthcare Coalition Resource and Gap Analysis tool are:

1. Will you meet all of the Conditions of Participation for CMS Emergency Preparedness by November 15?

Seventy-eight percent of respondents are required to meet the Conditions of Participation and of the seventy-eight percent, only fifteen percent (or two respondents) said they were going to be unable to meet the requirements. Those two respondents were unsure which requirements they were going to be unable to meet.

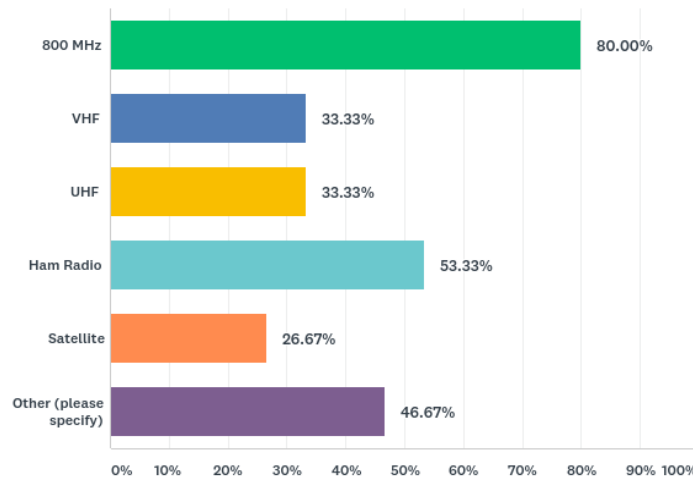
2. Does your facility have a provision for a second source of water?

Seventy percent of respondents said they had a second source of water. Of those, the majority reported the second source of water was bottled water. Three respondents reported having access to a water tank and one had a water bladder onsite.

3. Does your facility have a redundant Communications System?

Sixty-five percent of respondents reported they had redundant communications. The chart below displays the forms of redundant communications. "Other" included NXT Communicator, cell phones (5), two-way radios, and IMB lines.

Q26 What forms of redundant communication are available?



4. Do you have the ability to rapidly alert and notify?

Seventeen respondents answered this question with the majority reporting they have the ability to rapidly alert and notify patients, employees and visitors. The table below displays the responses from the respondents.

	YES	NO	N/A	TOTAL
Patients	64.71% 11	35.29% 6	0.00% 0	17
Employees	94.12% 16	5.88% 1	0.00% 0	17
Visitors	70.59% 12	29.41% 5	0.00% 0	17

The Coalition Survey is available upon request.

2.7 Compliance Requirements/ Legal Authorities

This section includes the legal authorities that inform and govern the coalition and its members, as related to emergency preparedness, focusing on primarily Centers of Medicare and Medicaid (CMS) Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.

The plan acknowledges that the following agencies play a crucial role in the success of our members:

- Accreditation Association for Ambulatory Health Care, Inc.
- Accreditation Commission for Health Care
- American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)
- American Osteopathic Association/Healthcare Facilities Accreditation Program
- Center for Improvement in Healthcare Quality (CIHQ)

- Community Health Accreditation Program (CHAP)
- DNV GL - Healthcare
- Healthcare Facilities Accreditation Program
- Institute for Medical Quality
- The Joint Commission
- The Compliance Team
- National Fire Protection Association (NFPA)

Please reference Appendix 5.4 for a crosswalk between the CMS Emergency Preparedness Final Rule Conditions of Participation and existing regulatory and accreditation standards.

3. Coalition Objectives

The section provides the elements to consider for the coalition when developing its objectives. The overarching goals of the coalition were voted upon at the January coalition meeting.

The goals are outlined below:

1. Build the foundation for healthcare and medical readiness.
2. Plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.
3. Provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled healthcare infrastructure.
4. Through collaborations and partnerships, deliver timely and efficient care to patients, even when the demand for healthcare services exceeds available supply.

A list of the goals, top priorities, new preparedness activities and reoccurring activities can be located in Appendix 5.5.

3.1 Maintenance and Sustainability

This section outlines maintenance and sustainability through the engagement of partners and stakeholders, while promoting the value of health care and medical readiness.

IHCC works towards sustainability through seeking out grants, in-kind donation of time, resources and continued engagement with its members and the community.

IHCC, its members, and community partners sharing leading practices and lessons learned. Often, these practices and lessons shared during the monthly meeting to help foster discussion among the group.

3.2 Engagement of Partners and Stakeholders

This section addresses the structure for engaging executives, clinicians, leaders, etc.

3.2.1 Health Care Executives

This section addresses how the coalition has engaged and continues to engage health care executives or designee. The expectation is all members report to their organizational leadership to keep executive leadership aware of the activities of IHCC.

3.2.2 Clinicians

This section addresses how the coalition has engaged, and continues to engage, health care delivery system clinical leaders to provide input, acknowledgment, and approval regarding strategic and operational planning. The following organizations are engaged in the coalition:

- Northern Nevada Infection Control
- Washoe County Medical Society

3.2.3 Community Leaders

This section addresses how the coalition has engaged, and continues to engage community leaders.

The coalition participates in the following meeting to engage community leaders.

- Prepare Washoe
- Washoe County Emergency Preparedness Council
- Washoe County Local Emergency Preparedness Committee

3.2.4 Children, Pregnant Women, Seniors, and Individuals with Access and Functional Needs

This section address how the coalition and its members have conducted inclusive planning for the whole community with agencies representing children; pregnant women; seniors; individuals with access and functional needs; individuals with pre-existing, serious behavioral health conditions; and others with unique needs. It is important to note, these individuals may require additional assistance before, during, and after an emergency.

Additional planning considerations include the following:

- People with Disabilities – The U.S. Census Bureau estimates that as of 2010 there were over 41,500 people with disability status.
- Poverty Level – The U.S. Census Bureau (2010) estimates 12.6 percent of the population was below the poverty level.

- Non-English Speakers – The U.S. Census Bureau estimates that as of 2010 there were over 91,000 people – nearly 22% of the County’s population – who speak a language other than English at home.
- Children – The 2010 preschool and school-age population (0-19 years of age) was approximately 112,042.
- Retirees – The 2010 retired population (65+) was approximately 51,000.
- Incarcerated People – The Washoe County Detention Center houses approximately 1,085 inmates at any given time.

Every 6 months, the coalition receives the [HHS emPOWER](#) De-Identified Aggregated data for Washoe County. The data should be used for preparedness planning and it is understood it does not reflect the entire population of Washoe County. As of November 2017, Washoe County has approximately 70,000 Medicare beneficiaries of which over 6,000 are electricity-dependent beneficiaries¹. The electricity-dependent beneficiaries include ventilator, BiPAP, internal feeding, UV infusion pump, at-home dialysis, electric wheelchair, electronic bed equipment, oxygen concentrator, and implanted cardiac device.

4. Workplan

This section focuses on roles and responsibilities of the coalition for executing its preparedness guide. The coalition secretary is the primary responsible entity for coordinating efforts to achieve the short and long-term objectives.

Ad-hoc and standing committees may be created by the coalition chair as needed, to further the objectives. Both voting and non-voting member representatives are eligible to serve on committees; however, only voting member representatives may be appointed as committee chairs.

A checklist of the coalition’s proposed activities is located in Appendix 5.6. This checklist is fluid document and includes the short-term and long-term objectives as identified by anticipated completion dates. Please reference the most up-to-date checklist for the status of the activities.

The checklist will be reviewed during coalitions meetings and the person responsible or designee for identified activities will give a progress report to the coalition. This will allow for accountability for the completion of the activities.

4.1 Roles and Responsibilities

This section focuses on roles and responsibilities of the coalition for executing its preparedness guide.

¹ <https://empowermap.hhs.gov/>

The chair is primarily responsible for the execution of the plan and may delegate responsibility as appropriate.

5. Appendices

This section contains detailed information on the HVA, resource and gap analysis, commitment to participate, compliance requirements/ legal authorities and the program guide and budget.

5.1 Commitment to Participate

The coalition recognizes the importance of community partners and membership engagement. To reinforce the importance, the IHCC Memorandum of Understanding (MOU) was developed and signed by all voting and non-voting members. This MOU outlines the expectations, benefits and privileges of being a coalition member.



This Memorandum of Understanding (MOU) is made and entered between the Inter-Hospital Coordinating Council (IHCC) and [organization/business/individual/institution] (Member). The agreement creates a voluntary agreement on common goals and expectation.

The IHCC was organized in 1994 for the purpose of collaborating and coordinating the efforts of healthcare facilities and other community stakeholders to mitigate against, prepare for, respond to, and recover from hazards impacting Northern Nevada's healthcare community and patients. The IHCC is a healthcare preparedness coalition and is not a response entity.

Expectations of Members:

- Assign a primary and secondary representative to the IHCC.
- Complete Incident Command System courses (ICS) 100, 200, 700 and 800.
- Leadership completion of ICS 300 and 400 is recommended.
- Miss no more than two consecutive meetings.
- Participate in the review of preparedness plans as deemed appropriate from the IHCC.
- Participate outside of the once a month meeting, as needed.
- Participate in situational awareness initiatives.
- Participate in the IHCC survey and HVA.
- Respect all other members.

Member Benefits and Privileges:

- Participation in collaboration, projects, capacity building and other efforts.
- Participation in meetings, trainings, workgroups/subcommittees related to healthcare preparedness.
- Increased partnerships in the community.
- Increased understanding of healthcare preparedness planning.
- Meet accreditation standards, as applicable.

State of Agreement

This Memorandum of Understanding (MOU) reflects an entirely voluntary commitment among the parties to cooperate and work together to achieve the purpose of the IHCC. This MOU in no way obligates or restricts the activity of any party in any way. No Member shall obligate, or purport to obligate, any other member with respect to any matter. Any party may withdraw from the IHCC at any time with 30-day written notice. Members agree to the above expectations and further agree that they read and understood this agreement.

Primary Member-Please PRINT

email: _____

24-hr Phone: _____

Secondary Member-Please PRINT

email: _____

24-hr Phone: _____

_____ Date

IHCC Chair

IHCC Vice Chair

IHCC Member-at-Large

5.2 Detailed Information on HVA

*Electronic version available upon request.

INTERHOSPITAL COORDINATING COUNCIL HAZARD VULNERABILITY ANALYSIS - WEIGHED SUMMARY																					
Organization	CHA	Donor Network West	IVCH	Life Care Center	ManorCare Wingfield	NNAMH S	NNMC	Quail	Renown Hospice	Renown Rehab Hospital	Renown Regional	Renown South Meadows	Rosewood Skilled	SMRMC	Summit Surgery	SCOR	Tahoe Forest	Tahoe Pacific	HVA Total	Weighted HVA	
Active Shooter	7%	2%	19%	22%	11%	56%	24%	3%	33%	67%	67%	67%	7%	37%	4%	4%	19%	67%	29%	43%	
Acts of Intent	8%	3%	0%	8%	8%	0%	11%	0%	33%	18%	33%	33%	15%	44%	0%	4%	0%	33%	14%	21%	
Bomb Threat	8%	2%	33%	13%	12%	44%	44%	4%	10%	33%	33%	33%	7%	15%	4%	4%	33%	11%	19%	29%	
Building Move	5%	0%	0%	20%	0%	0%	22%	0%	12%	33%	33%	33%	0%	19%	0%	7%	0%	0%	10%	16%	
Chemical Exposure, External	0%	0%	15%	0%	10%	15%	0%	5%	21%	33%	33%	33%	0%	20%	4%	2%	72%	0%	15%	22%	
Civil Unrest	7%	1%	13%	3%	10%	15%	44%	1%	16%	33%	33%	33%	0%	19%	0%	3%	13%	0%	14%	21%	
Communication / Telephony F	4%	0%	33%	3%	10%	11%	17%	7%	29%	33%	67%	33%	6%	22%	13%	3%	33%	22%	19%	29%	
Dam Failure	0%	0%	0%	8%	0%	0%	0%	0%	0%	33%	33%	33%	0%	44%	0%	4%	11%	0%	9%	14%	
Drought	3%	0%	11%	3%	9%	22%	33%	0%	16%	33%	33%	33%	0%	44%	0%	4%	11%	22%	16%	23%	
Earthquake	17%	0%	41%	33%	24%	83%	56%	9%	33%	33%	44%	33%	10%	78%	20%	13%	41%	50%	34%	52%	
Epidemic	8%	0%	33%	9%	13%	19%	28%	4%	18%	33%	67%	33%	0%	33%	0%	3%	33%	11%	19%	29%	
Evacuation	16%	0%	17%	13%	15%	0%	17%	7%	29%	67%	67%	33%	7%	24%	8%	2%	17%	33%	21%	31%	
Explosion	7%	0%	0%	9%	14%	0%	22%	11%	24%	33%	33%	33%	0%	26%	0%	4%	0%	17%	13%	20%	
External Flood	12%	0%	26%	31%	12%	39%	83%	4%	27%	33%	33%	33%	0%	56%	0%	6%	26%	50%	26%	40%	
Fire	6%	2%	44%	25%	33%	11%	83%	10%	27%	33%	33%	33%	31%	61%	12%	8%	44%	33%	30%	45%	
Flood	12%	0%	15%	22%	11%	30%	56%	3%	27%	33%	33%	33%	0%	56%	0%	7%	26%	30%	22%	33%	
Forensic Admission	8%	0%	0%	0%	0%	0%	17%	0%	0%	33%	33%	33%	0%	33%	0%	3%	0%	33%	11%	16%	
Gas / Emissions Leak	7%	0%	26%	11%	12%	15%	22%	4%	9%	33%	33%	33%	6%	15%	0%	3%	26%	11%	15%	22%	
Generator Failure	14%	0%	17%	3%	10%	13%	67%	6%	0%	33%	33%	33%	6%	13%	2%	8%	17%	22%	17%	25%	
Hazmat Incident	6%	0%	11%	3%	13%	11%	28%	8%	16%	33%	33%	33%	0%	33%	0%	3%	11%	11%	14%	21%	
Hazmat Incident with Mass Ca	8%	0%	41%	3%	14%	37%	56%	4%	21%	33%	67%	33%	0%	33%	0%	4%	41%	0%	22%	33%	
Hostage Situation	8%	2%	19%	3%	12%	0%	28%	4%	15%	33%	33%	33%	0%	17%	0%	4%	19%	33%	15%	22%	
Hurricane	0%	0%	0%	0%	0%	0%	0%	0%	0%	33%	33%	33%	0%	44%	0%	0%	0%	0%	8%	12%	
HVAC Failure	4%	0%	13%	3%	12%	33%	22%	7%	4%	33%	33%	33%	6%	11%	13%	5%	13%	0%	14%	21%	
Inclement Weather	4%	3%	50%	11%	19%	0%	50%	8%	31%	33%	33%	33%	0%	50%	3%	5%	50%	67%	25%	38%	
Infectious Disease Outbreak	8%	0%	30%	17%	10%	0%	17%	4%	9%	33%	33%	33%	0%	20%	0%	3%	30%	22%	15%	23%	
Internal Fire	6%	0%	19%	28%	22%	22%	17%	9%	9%	33%	33%	33%	6%	19%	13%	7%	19%	17%	17%	26%	
Internal Flood	12%	0%	13%	0%	10%	30%	11%	4%	16%	33%	33%	33%	6%	17%	3%	7%	13%	17%	14%	22%	
IT System Outage	4%	5%	13%	8%	9%	26%	28%	9%	20%	33%	33%	33%	6%	30%	12%	3%	13%	22%	17%	26%	
Landslide	5%	0%	0%	6%	0%	0%	22%	0%	11%	33%	33%	33%	0%	44%	0%	1%	22%	22%	13%	20%	
Large Internal Spill	0%	0%	15%	0%	0%	15%	0%	4%	0%	33%	33%	33%	0%	22%	0%	3%	11%	0%	9%	14%	
Mass Casualty Incident	8%	0%	33%	0%	0%	15%	56%	4%	9%	67%	67%	67%	0%	26%	0%	3%	50%	22%	24%	36%	
Natural Gas Disruption	5%	0%	26%	3%	11%	15%	33%	10%	13%	33%	33%	33%	6%	17%	0%	3%	26%	17%	16%	24%	
Natural Gas Failure	6%	0%	26%	3%	11%	15%	22%	10%	7%	33%	33%	33%	6%	19%	0%	3%	26%	17%	15%	23%	
Other	0%	0%	0%	19%	0%	0%	0%	0%	0%	33%	33%	33%	0%	0%	0%	0%	0%	0%	7%	10%	
Other Utility Failure	6%	0%	0%	0%	0%	0%	11%	3%	5%	33%	33%	33%	0%	13%	0%	3%	0%	0%	8%	12%	
Pandemic	8%	0%	0%	2%	12%	0%	22%	5%	9%	33%	33%	33%	0%	13%	0%	3%	0%	11%	10%	16%	
Patient Surge	9%	0%	15%	3%	8%	0%	44%	4%	18%	33%	33%	33%	0%	19%	0%	4%	33%	0%	14%	22%	
Picketing	7%	0%	0%	0%	0%	0%	11%	4%	7%	33%	33%	33%	0%	19%	0%	1%	0%	0%	8%	13%	
Planned Power Outages	4%	0%	0%	5%	9%	0%	22%	0%	29%	33%	33%	33%	0%	9%	0%	1%	0%	6%	10%	16%	
Power Outage	7%	0%	33%	17%	9%	11%	33%	7%	31%	33%	33%	33%	6%	19%	0%	3%	33%	22%	18%	28%	
Radiation Exposure	0%	0%	15%	0%	0%	30%	22%	4%	10%	33%	33%	33%	0%	28%	0%	3%	15%	0%	13%	19%	
Seasonal Influenza	7%	0%	0%	14%	8%	11%	17%	8%	20%	33%	33%	33%	6%	22%	10%	6%	0%	26%	14%	21%	
Sewer Failure	20%	0%	13%	3%	10%	26%	22%	9%	6%	33%	33%	33%	8%	15%	0%	3%	13%	7%	14%	21%	
Shelter in Place	7%	0%	22%	8%	8%	11%	33%	9%	24%	33%	33%	33%	0%	11%	0%	4%	11%	11%	14%	22%	
Strikes / Labor Action / Work	7%	2%	0%	0%	12%	11%	0%	5%	9%	33%	33%	33%	0%	20%	0%	4%	0%	0%	9%	14%	
Suicide	4%	0%	0%	0%	13%	30%	33%	1%	7%	33%	33%	33%	6%	9%	0%	3%	0%	11%	12%	19%	
Supply Chain Shortage / Failur	4%	0%	37%	14%	17%	11%	17%	7%	27%	33%	33%	33%	6%	30%	5%	7%	30%	22%	18%	28%	
Suspicious Odor	7%	0%	0%	0%	13%	11%	17%	4%	12%	33%	33%	33%	0%	11%	0%	3%	0%	11%	10%	16%	
Suspicious Package / Substar	7%	0%	0%	0%	13%	11%	11%	4%	7%	33%	33%	33%	0%	11%	0%	3%	0%	11%	10%	15%	
Temperature Extremes	4%	0%	33%	17%	11%	26%	50%	4%	18%	33%	33%	33%	0%	17%	0%	1%	33%	50%	20%	31%	
Tornado	0%	0%	0%	5%	14%	22%	0%	4%	9%	33%	33%	33%	0%	44%	0%	0%	0%	17%	12%	18%	
Transportation Failure	4%	4%	26%	4%	22%	11%	0%	0%	18%	33%	33%	33%	6%	11%	0%	3%	26%	56%	16%	24%	
Trauma	9%	0%	0%	9%	12%	15%	56%	1%	6%	33%	33%	33%	6%	22%	0%	3%	0%	0%	13%	20%	
Tsunami	0%	0%	0%	0%	0%	0%	0%	0%	13%	33%	33%	33%	0%	0%	0%	0%	0%	0%	6%	10%	
VIP Situation	7%	0%	26%	0%	0%	11%	33%	0%	18%	33%	33%	33%	0%	26%	0%	3%	26%	0%	14%	21%	
Water Contamination	7%	0%	0%	3%	12%	13%	22%	8%	8%	33%	67%	33%	8%	15%	0%	4%	0%	11%	14%	21%	
Water Disruption	5%	0%	19%	8%	9%	13%	22%	7%	9%	33%	33%	33%	6%	19%	0%	4%	19%	7%	14%	21%	
Weapon	7%	0%	19%	8%	10%	0%	33%	4%	10%	33%	33%	33%	6%	15%	0%	3%	19%	56%	16%	24%	
Workplace Violence / Threat	6%	2%	33%	3%	10%	11%	44%	4%	16%	67%	67%	67%	0%	30%	3%	3%	33%	28%	24%	36%	
Zombies	0%	0%	0%	0%	50%	0%	0%	0%	0%	33%	33%	33%	0%	0%	0%	0%	0%	0%	8%	13%	

5.3 Program Plan and Budget

The coalition has a financial subcommittee comprised of at least two members of leadership and one non-leadership core member. This subcommittee is responsible for reviewing and approving funds spent under the ASPR cooperative agreement and other secured funding. The subcommittee will also be provided an update of the ASPR Scope of Work monthly to ensure deliverables are achieved.

Please reference current budget for updated financials.

5.4 Compliance Requirements/ Legal Authorities Table

The below is only a screenshot of the [crosswalk](#) between the Emergency Preparedness CMS Conditions of Participation & accreditation organizations created by the Yale New Haven Center for Emergency Preparedness and Disaster Response.

CMS Emergency Preparedness Conditions of Participation Language	CMS Emergency Preparedness Conditions of Participation Reference	American Association for Accreditation of Ambulatory Surgery Facilities www.aaaaf.org/	NFPA 1600	NFPA 99
Communication Plan	Communication Plan			
Be required to develop and maintain an emergency preparedness communication plan that complies with local, state and Federal law and required to review and update the communication plan at least annually.	485.727 (C)		6.4	12.5.3.3.6.1
As part of its communication plan include in its plan, names and contact information for staff; entities providing services under arrangement; patients' physicians; other organizations and volunteers.	485.727 (C) (1)			
Require contact information for Federal, State, tribal, regional, or local emergency preparedness staff and other sources of assistance.	485.727 (C) (2)		6.4.1	12.5.3.3.6.1(6)
Include primary and alternate means for communicating with staff and Federal, State, tribal, regional, and local emergency management agencies	485.727 (C) (3)		6.4.1	12.5.3.3.6.1(6)
Include a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care.	485.727 (C) (4)			12.5.3.3.6.1(4)
Have a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.	485.727 (C) (5)			12.5.3.3.6.1(2)(6)
Training and Testing	Training and Testing			
Develop and maintain an emergency preparedness training and testing program based on the emergency plan, risk assessment, policies and procedures and communications plan. The training and testing program must be reviewed and updated at least annually.	485.727 (d)			12.3.3.10

5.5 2018 Goals and Objectives



2018 Goals and Objectives Inter-Hospital Coordinating Council

Goals:

1. Build the foundation for healthcare and medical readiness.
2. Plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.
3. Provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled healthcare infrastructure.
4. Through collaborations and partnerships, deliver timely and efficient care to patients, even when the demand for healthcare services exceeds available supply.

The top preparedness gaps by provider type, as identified through the coalition's resource and gap analysis are as follows:

EMS/FIRE:

1. EMS Active Shooter/Armed Assailant/Active Threat Response
2. EMS Exercise Plan
3. EMS Specialty Mass Casualty Plan

Hospital:

1. Hospital Surgical/Burn MCI Plan
2. Hospital COOP, Recovery/Business Continuity Plan
3. Hospital Pediatric MCI Plan

Long-term Care (LTC):

1. LTC Infectious Disease Plan
2. Evacuation Plan (alternate care site)
3. LTC Exercise Plan

Public Health:

1. Alternate Care Site Plan
2. Public Health Shelter Support Plan (medical services)
3. Public Health Legal/Regulatory Plan

Outpatient:

1. Outpatient Care Emergency Operations Plan
2. Outpatient Care Staff and Resources Sharing Plan/ Care Surge Capacity Plan

New preparedness activities:

1. No notice/low notice medical surge exercise
2. Response plan
3. Regional triggers
 - a. Assets/resources – supply chain
4. Regional visitation policies
5. Workshops/Trainings
 - a. HVA
 - b. EOPs
 - c. COOPs
6. Annual Evaluation

Reoccurring preparedness activities:

1. MAEA training
2. MCIP training
3. ICS 300 and 400
4. Healthcare Requesting Form training
5. Coalition HVA
6. Preparedness Planning Guidelines revisions
7. MCIP revisions
8. MAEA revisions

5.6 Checklist of proposed activities

This checklist is fluid document. Please reference the most up-to-date checklist for the status of the activities.

Checklist of Proposed Activities						
Provider Type	Top Priorities	Activities	Person Responsible	Agency	Anticipated Completion Date	Date Completed
EMS/ Fire	EMS Active Shooter/Armed Assailant/Active Threat Response					
	EMS Exercise Plan					
	EMS Specialty /Mass Casualty Plan					
Hospital	Hospital Surgical/ Burn MCI Plan					
	Hospital COOP, Recovery/Business Continuity Plan					
	Hospital Pediatric MCI Plan					
Long-Term Care	LTC Infectious Disease Plan					
	Evacuation Plan (alternate care site)					
	LTC Exercise Plan					
Public Health	Alternate Care Site Plan					
	Public Health Shelter Support Plan (medical services)					
	Public Health Legal/Regulatory Plan					
Outpatient	Outpatient Care Emergency Operations Plan					
	Outpatient Care Staff and Resources Sharing Plan/Care Surge Capacity Plan					
	ASPR Grant Deliverables	*Reference ASPR scope of work for complete list of activities and progress	Andres Bp	WCHD/IHCC	6/30/2018	
New Preparedness Activities	No notice/low notice medical surge exercise					
	Response plan					
	Regional triggers					
	Regional visitation policies					
Reoccurring Preparedness Activities	Workshops/ trainings					
	IMBAE Training					
	MCIIP Training					
	ICS 300 and 400 training					
	Healthcare Requesting Form Training					
	Coalition HVA					
	Preparedness Planning Guidelines revisions					
	MCIIP revisions					
	IMBAE revisions					